Iowa Department of Human Services

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INFORMATIONAL LETTER NO. 1042

DATE: August 22, 2011

TO: Iowa Medicaid Hospitals (Excluding Indian Health Service Providers)

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Observation Care Services

EFFECTIVE: September 1, 2011

The purpose of this Informational Letter is to notify hospitals of changes for billing for observation care services provided in the outpatient hospital.

Effective for dates of services (DOS) on and after September 1, 2011, the IME will implement billing code changes related to observation care services. It is the intent of the IME to remain consistent with Medicare coverage and billing policies.

Definition of Observation

Observation is a defined set of clinically appropriate specific services that include ongoing short-term treatment, assessment and reassessment before deciding whether a Medicaid member requires further treatment as a hospital inpatient or to be discharged from the hospital outpatient department.

Outpatient Observation Service Coverage

A Medicaid member admitted to observation status is considered a hospital outpatient. Observation services must be reasonable and necessary, and ordered by a physician or another individual authorized by State licensure law to order tests or admit patients to the hospital.

Under the Outpatient Prospective Payment System (OPPS), reimbursement for observation services is packaged into the payment for other separately reimbursed services rendered on the same day. A separate Ambulatory Payment Classification (APC) payment may be made for observation services. Additional guidelines and information for separately reimbursable observation services are provided in the Billing Guidance and Reimbursement Information section of this Informational Letter.

Observation Time

- Time begins at the time documented in the patient's medical record that coincides with the time that observation care is initiated in accordance with a physician's order.
- Time ends when all medically necessary services related to observation care are completed, including follow-up care furnished by hospital staff and physicians that may

take place after a physician has ordered the patient be released or admitted as an inpatient.
- The hours must equal or exceed eight hours.
- Observation care is usually less than 24 hours. Only in rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Current Billing Process

Prior to September 1, 2011, providers billed observation services per day to the IME using procedure code 99218.

New Billing Guidance

Beginning September 1, 2011, providers must bill using the following guidance:

- Observation claims must be submitted with type of bill (TOB) 13x.
- Report the total number of units (hours) for the entire observation stay on a single claim line.
- The DOS for the observation claim line is the date the Medicaid member is admitted to observation status.
- The OPPS claims processing logic determines the APC assignment (i.e., whether the observation services are packaged or separately payable).
- Revenue Codes:
  - 0760 General Classification Category
  - 0762 Observation Hours
- HCPCS Code G0378 Hospital Observation Services, per hour.
  - Hourly observation services are assigned to status indicator "N", signifying that its payment is always packaged.
- HCPCS G0379 – Direct referral for hospital observation care
  - Report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit or critical care service on the day of initiation of observation services.
- The claim for observation services must include one of the following services:
  - Emergency room.
  - Clinic visit.
  - Critical care.
- No procedure with a "T" status indicator can be reported on the same day or on the day before observation care is provided.
- Report any other ancillary services performed while the Medicaid member is in observation status using the appropriate revenue and HCPCS codes as applicable.

Reimbursement Information for Separate APC Payment

To receive a separate composite APC payment for observation care, the following criteria applies:

APC 8002-Level I Extended Assessment and Management Composite

This APC requires a level 99205 or 99215 clinic visit on the day of or the day before observation or a direct admission to observation (reported with procedure code G0379). In

addition, at least 8 units of G0378 (Observation services, per hour) must be reported and no procedure with a status indicator of T (significant procedure subject to multiple procedure discounting).

APC 8003-Level II Extended Assessment and Management Composite
This APC requires a level 99284 or 99285 Type A ED visit, a G0384 level 5 Type B ED visit, or 99291 critical care to be reported on the day of or day before observation. In addition, at least 8 units of G0378 (Observation services, per hour) must be reported and no procedure with a status indicator of T (significant procedure subject to multiple procedure discounting).

These composite APCs are reimbursed as a single payment for the combination of an ED or clinic visit, or a direct referral to observation with an observation visit instead of a separate payment for the observation and the ED or clinic visit.

If either of the above criteria is not met, observation services will be assigned status indicator "N" and will be packaged into payment for other separately payable services provided in the same encounter.

If you have any questions, please contact the IME Provider Services Unit, 1-800-338-7909, locally 515-256-4609 or by email at imeproviderservices@dhs.state.ia.us.